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Abstract: **Rationale:** Patients with long-term mental health conditions often have complex physical, mental and social needs. They are high users of the acute general healthcare system, but can experience stigmatising attitudes and behaviours, and structural discrimination. We wished to improve understanding of stigmatisation in the acute healthcare setting, to target areas for future intervention. **Objective:** A synthesis of qualitative literature was undertaken in order to understand how patients with long-term mental health conditions are stigmatised, or otherwise, within the acute healthcare system. **Method:** A theory-driven framework approach was taken. Existing stigma theory was used to outline a framework for categorising stigmatising and non-stigmatising phenomena within the acute healthcare system. **Results:** A systematic literature search of qualitative studies identified a sample of 51 studies that would inform the framework. Using data in these studies, a final theoretical 'best fit' framework was developed. In this framework there is an overarching pattern of labelling and stereotyping, plus five ways in which patients with mental health conditions are stigmatised in the acute healthcare system: through devaluation, social control, avoidance, rejection and failure to act. In addition, the framework outlines positive attitudes and behaviours - valuing, adjustment, responding, legitimising and positive action - which contrast with the stigmatisation patterns. **Conclusions:** The study offers a framework for identifying stigmatisation and positive treatment of those with mental health conditions in an acute health setting. This framework is of potential value in targeting areas for improved quality of care and may have utility beyond this setting and stigmatised group.

Stigmatisation of those with mental health conditions in the acute general hospital setting: A qualitative framework synthesis

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Abstract

Rationale. Patients with long-term mental health conditions often have complex physical, mental, and social needs. They are frequent users of the acute general healthcare system, but can experience stigmatizing attitudes and behaviours, and structural discrimination. We wished to improve understanding of stigmatization in the acute healthcare setting, to target areas for future intervention. *Objective.* A synthesis of qualitative literature was undertaken in order to understand how patients with long-term mental health conditions are stigmatized, or otherwise treated, within the acute healthcare system. *Method.* A theory-driven framework approach was implemented. Existing stigma theory was used to outline a framework for categorizing stigmatizing and non-stigmatizing phenomena within the acute healthcare system. *Results.* A systematic literature search of qualitative studies identified a sample of 51 studies that would inform the framework. Using data in these studies, a final theoretical 'best fit' framework was developed. In this framework there is an overarching pattern of labelling and stereotyping, plus five ways in which patients with mental health conditions are stigmatized in the acute healthcare system: devaluation, social control, avoidance, rejection, and failure to act. In addition, the framework outlines positive attitudes and behaviours – valuing, adjustment, responding, legitimizing, and positive action – which contrast with the stigmatization patterns. *Conclusions.* The study offers a framework for identifying stigmatization and positive treatment of those with mental health conditions in an acute health setting. This framework is of potential value in targeting areas for improved quality of care and may have utility beyond this setting and stigmatized group.

KEYWORDS

Stigmatisation; discrimination; mental health; acute healthcare; emergency care; qualitative synthesis; critical realist

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BACKGROUND

People with long term mental health conditions are high users of the acute general healthcare system (Dorning et al., 2015). Many with psychotic disorders, personality disorders, mood and anxiety disorders, and drug and alcohol use disorders have poor general health, with increased risk of developing long term physical conditions (Hert et al., 2011; Thornicroft, 2011; BMA 2014; Woodhead et al., 2014). Their overall life expectancy is considerably reduced - by one to two decades in higher income countries such as the UK, Scandinavia and Australia, and three decades in, for example, rural Ethiopia (Chang et al., 2011; Hayes et al., 2011; Wahlbeck et al., 2011; Fok et al., 2012; Lawrence et al., 2013; Nordentoft et al., 2013; Fekadu et al., 2015; Olfson et al., 2015). Patients with such mental health conditions are more likely to attend the emergency department, and to be subsequently admitted, than those without (Keene et al., 2007; Dorning et al., 2015). In a 2015 report, 81% of such admissions in English NHS hospitals were for physical problems, and not for problems directly related to their mental health condition (Dorning et al., 2015).

It is therefore concerning that patients with mental disorders report negative attitudes and discrimination in the acute healthcare setting (Clarke et al., 2007). Studies have shown stigmatising attitudes towards this group among acute care staff (Clarke et al., 2014, Henderson et al., 2014), while interview- and survey-based studies of health professionals indicate that stigma may affect decision-making (Hert et al., 2011; McCormack et al., 2013; Clarke et al., 2014). Furthermore, quantitative disparities in acute clinical care for patients with mental health conditions have been widely described (Mitchell et al., 2009).

Does stigmatisation therefore lead to lower quality of care, and worse outcomes, for those with mental health conditions in the acute healthcare setting? The situation is not straightforward, due to the complexities of presentation and high social needs of such patients, who are often seen as challenging (Happell et al., 2012; Shefer et al., 2014). Stigmatising practices might also be mitigated by professional ethos, perceived duties of care, and compassion (McCormack et al., 2013). Disentangling

these factors is key to ensuring that this patient group receive high quality of care – care that is safe, effective, patient-centred, timely, efficient and equitable (Knaak et al., 2015).

This study was undertaken to synthesise the qualitative literature, to better understand how patients with mental health conditions are stigmatised, or otherwise, in the acute healthcare system.

STIGMATISATION

Stigma, a ‘spoiled identity’, was originally described by Goffman from an interactionist perspective (Goffman, 1963) and early stigma theory emphasised the effects of stigma on the individual. While this enabled a sophisticated understanding of the effects of stigma, it hindered recognition of stigmatisation as a ‘doing-to’ action, and the differential treatment of vulnerable groups may have passed unchallenged.

More recently there has been a shift toward approaching stigma from a critical viewpoint, focusing on the individual or structure ‘doing’ the stigmatising. From this perspective, stigmatisation has been aligned with concepts of prejudice, discrimination and oppression (Phelan et al., 2008; Scambler, 2009; Holley, 2012). Defining stigma as co-occurrence of its components, of labelling, stereotyping, separation, status loss, and discrimination, Link and Phelan (2001) assert that for stigmatisation to occur, power must be exercised. This ‘stigma power’ (Link and Phelan, 2014) is seen as a form of ‘symbolic power’, a concept introduced by Bourdieu (1989). Proposed functions of stigma power are to keep out-groups ‘down’, or dominated/exploited; to keep them ‘in’, in order to maintain social norms, and to keep them ‘away’, a process characterised by patterns of avoidance (Phelan et al., 2008; Link and Phelan, 2014).

In the current study we wished to maintain this critical viewpoint and apply it to a group of people identified by a mental health condition. The Weiss (2006) formulation provides a working definition of health-related stigma which aligns with a critical perspective:

Stigma is typically a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted.

The latter part of this definition, ‘medically unwarranted’, is pertinent to the acute healthcare setting, and helps distinguish the social process of stigmatisation from ‘ordinary’ categorisation, clinical decision-making, everyday frustrations and pragmatics of acute patient care.

The current study also differentiates stigmatising attitudes from stigmatising behaviours, as proposed by Thornicroft et al. (2007). Within ‘stigmatising attitudes’ we include emotional responses, which Link et al. (2004), added to their earlier stigma conceptualisation.

CRITICAL REALISM

This study was designed within a critical realist paradigm (Bhaskar, 2013) which has been proposed as a useful metatheoretical approach to qualitative synthesis (Brannan et al., 2017).

The components of critical realism are ontological realism, epistemic relativism, judgmental rationality and a cautious ethical naturalism (Archer et al., 2016). Critical realism regards constructs such as stigmatisation as reflecting an underlying social reality (‘ontological realism’) – however, epistemologically we cannot ‘know’ this reality. We need to be aware of this limitation (‘epistemic relativism’), and social processes like stigmatisation need to be interpreted contextually and relatively. We can, however, identify partial regularities that help to understand ways in which stigmatisation operates.

Another useful theme of critical realism is ‘emergence’, in which social entities can be regarded as stratified. Patterns of stigmatisation might ‘emerge’ at intrapersonal, interpersonal and

structural levels. This aligns with the individual and structural forms of stigmatisation, as described by Corrigan (2000).

The critical realist perspective thus allows mapping of partial regularities across qualitative sources of different designs, and from different settings, at different sociological levels. This is carried out in the current study by systematic synthesis, using 'judgemental rationality'.

Through a critical realist lens, there is also an acknowledgement that concepts such as stigmatisation are value-laden, and that investigation of stigmatisation has something to say about values ('ethical naturalism'). There is a dialectical aspect to social ills such as stigma, and identifying instances where such ills are overcome is a key step in moving toward transformation (Bhaskar, 2008). To fully understand stigmatisation, it must therefore be necessary to identify positive attitudes and behaviours as well as stigmatisation, while being mindful of setting up a falsely dichotomous view of 'good' and 'bad' care. This might then help in understanding complexities of care, and how alternatives to stigma may translate to everyday practice, and thus aid in design of a transformative approach via staff- and organisational-level interventions.

METHODOLOGY

AIM

The aim of this study was to identify patterns of stigmatisation in qualitative studies that focus on the care of those with mental health conditions in the acute healthcare setting.

SCOPE

The synthesis involved qualitative studies. It excluded a body of quantitative literature addressing inequalities of acute healthcare for those with mental disorders (Mitchell et al., 2009) because many such studies are from the US, where intricacies of the health system complicate analysis and interpretation. Furthermore, these studies generally do not illuminate the processes that lead to inequalities: there is rarely any distinction made, for example, between patients who were not offered a procedure, and those who declined a procedure, nor whether informed choices were made, and appropriate adjustments considered. Qualitative studies permit deeper exploration of issues, and were deemed more useful in developing a theory-based model.

STUDY DESIGN

Methodologies for qualitative synthesis are diverse. Most are based, like the primary literature they aim to synthesise, on inductive techniques. Since we wished to use existing stigma theories to drive the synthesis, however, we chose a deductive 'best fit' framework approach to synthesis, that utilises and expands on an *a priori* conceptual model (Carroll et al., 2011). As a variation of this approach, stigma theory was used to define the preliminary framework.

Existing theoretical models of stigma were used to construct an *a priori* framework (Table 1). This framework incorporated the 'down', 'in' and 'away' stigma functions described by Phelan et al. (2008). The framework also distinguished stigmatising attitudes from stigmatising behaviours

(Thornicroft et al., 2007), and individual and structural forms of stigmatisation (Corrigan 2000). Also incorporated were ‘contra-stigmatising’ attitudes and behaviours. <Insert Table 1>

SEARCH STRATEGY

The search strategy was designed to keep the total yield manageable (see Table 2). Only English language studies from 1996-2019 were included. Criteria were grouped in columns and search words in each column searched simultaneously (eg Mental OR Schizophren* OR Bipolar OR...). Initially, the group combinations shown in the table were searched for in Titles only. Study design was then added as a further constraint, focus terms searched within Titles, and remaining terms searched within Titles and Abstract. <Insert Table 2>

{FOCUS AND (Setting OR Comorbidity) AND (Perspective OR Differential OR Decisions)} [Titles]

OR

FOCUS [Titles] AND {(Setting OR Comorbidity)[Titles/Abstract] AND (Perspective OR Differential OR Decisions) [Titles / Abstract] AND (Study design) [Titles / Abstract]}

The searches were initially undertaken in 2016 for years 1996-2016, and repeated in August 2019 for years 2016-19 only. The following databases were searched: *Medline / Pubmed / Google Scholar / Embase / Psycharticles / Psychinfo / HMIC / Social Policy and Practice / Global Health / Web of Science / Social Science (Proquest) / British Nursing / Applied Social Sciences Index & Abstracts / Cumulative Index to Nursing and Allied Health Literature / King’s College London Library / Cochrane / Public Health / King’s Fund / Picker Institute / Healthwatch / National Institute for Health and Care Excellence (NICE) / Social Policy Research Unit.* An example search is illustrated in the Appendix.

SAMPLING STRATEGY

Due to the theory-driven aims of the study and the divergent subject matter, a closed 'set' of studies for inclusion in the review was not sought. Like previous authors of syntheses (Dixon-Woods et al., 2005), we used sampling techniques derived from primary qualitative research, including purposive sampling, maximum variation and snowballing, to identify the literature sample. In our approach, we generated a large sampling frame from an initial broad search, using varied search terms and large number of databases. Inclusion and exclusion criteria were used to narrow the sample (see Table 3). In complex studies that met both inclusion and exclusion criteria, studies were retained for further appraisal. <Insert Table 3>

Snowballing was used to expand the sample by backwards and forwards chaining. Backwards chaining was achieved by appraising studies drawn from the references within the literature sample. Forwards chaining was undertaken by identifying papers that had cited those in the sample, in order to identify more recently published papers of significance. Abstracts and full texts were screened by the primary reviewer (AP) according to the screening sheet in Figure 1. <Insert Figure 1>

STUDY SELECTION

After appraisal of the full text by the primary reviewer (AP), studies were selected on the basis of two further criteria: if they were relevant to the aim of the current study, and if they had internal validity. Perceived quality of a study was not used as a criterion as we believed that studies of relatively low quality might still contain useful findings. Care was also taken to ensure widest possible variation of features including study type, subgroup of patients studied, geographical setting, and type of participant.

Study relevance was regarded as any of: direct exploration of stigma; examination of professionals' attitudes; reports or investigation of differential care and naturalistic studies of the acute healthcare of those with mental health conditions. Where this was a clear central feature of the study, this study was deemed to have strong relevance to the synthesis.

Internal validity was judged using criteria of consistency and logic: that is, the aims and objectives, the methods of data collection and the analyses and presentation of findings were derivable from the methodology. For narrative pieces such as case reports, there needed to be a sequential account of events, rather than simply description and opinion. Logical consistency was judged by the primary reviewer (AP) and papers of uncertain internal validity were discussed within the group monthly alongside those of debatable relevance.

After discussion, the studies were divided into two groups: the primary sample for analysis and a secondary sample. The secondary sample consisted of studies that fulfilled inclusion criteria only to a limited extent (for example, where much of the study was quantitative in design), or that were only tangentially relevant, or that were from 'grey' (unpublished) sources such as doctoral theses. Reviewers considered the possibility that these studies might contain patterns of stigmatisation that would be overlooked in the framework. These studies were therefore maintained to ensure completeness and check validity of the framework after it was developed (see below).

DATA EXTRACTION

Data extracted from studies were any that were considered as stigmatisation after appraisal and, where necessary, group discussion. This might describe a professional's attitude - either cognitive or emotional - professional behaviour, or organisational structure. The Weiss (2006) definition of stigma above was considered in identifying relevant data. Specifically, stigmatisation was identified if attitudes, behaviours or structures appeared to arise from an adverse social judgment based on the presence of a mental health condition, and if that judgment was medically unwarranted. In some instances, where the text did not make some of these aspects clear, discussion among reviewers was used to decide whether a particular instance should be considered stigmatisation.

Data were extracted from the results sections of individual papers and included descriptions of primary data, and examples of primary data (usually quotations).

FRAMEWORK DEVELOPMENT

Data were fitted, where possible, into the *a priori* framework by the primary reviewer (AP). Primary data and descriptions of findings that did not appear to belong in the matrix were recorded separately. At monthly meetings, the emerging matrix was reviewed, and fitting of data within categories was critiqued, with reference to original papers to provide context where necessary. Decisions to leave data out of the *a priori* matrix were critically challenged, and this data was set aside.

Non-fitting data were discussed as 'deviant cases' and commonalities were sought. New categories were proposed to the group, with reattempts to fit the data into these categories. This continued until the expanded framework was considered to encompass all identified patterns of stigmatisation of those with mental health conditions in the sample pool, as well as contrasting examples of positive treatment.

The final framework was applied to the secondary sample to ensure saturation of concepts and validity of the framework. This technique corresponds to that described by Lincoln and Guba (1985) as 'referential adequacy'. It also served to overcome any issues of reliability, where individual appraisers might differ as to the relevance of the study, as less relevant studies were maintained in the second sample. An updated search sample for the years 2016-2019 was also checked against the final framework, to ensure that further patterns of stigmatisation had not become identifiable since the original search. A flowchart for this study (Figure 2) is included to provide an idea of the iterative processes involved. <Insert Figure 2>

RESULTS

LITERATURE SAMPLE

The initial search yielded 2345 papers, with the updated (2016-2019) search adding a further 889 papers. 153 abstracts that met inclusion criteria were screened. The full texts of these papers were analysed for exclusion criteria, and 89 papers that met criteria were selected for a snowballing approach using backwards and forwards chaining. Backwards chaining was achieved by selecting relevant studies from the references within the paper, and forwards chaining using the 'cited by' function of Google Scholar. A pool of 199 papers were then appraised in full, and 51 papers were subdivided into a main sample (26 papers) and a secondary sample (25 papers). The main sample consisted of 26 papers of relevance published between 1996 and 2016. These contributed the data for the framework development. The secondary sample consisted of unpublished works (4 studies); published works of lower relevance (10 papers), and papers from an updated search, from 2016-19 (11 papers).

The full sample comprised interview and focus group studies (28 studies), ethnographies (8 studies), case reports (4 studies) and 11 mixed or other studies. The studies addressed: acute physical presentations to hospital in those with mental disorders (3 studies); the acute general healthcare of those with mental disorders (16 studies); tangential socially-defined groups in the acute hospital setting (the homeless; frequent attenders; violent patients) where those with mental disorders featured significantly (11 studies); those with substance or alcohol use disorder and physical health needs in the acute hospital setting (10 studies); those with an acute presentation related to self-harm (5 studies); those with a physical presentation and co-existing mental disorder who declined intervention (4 studies); and uncategorised relevant studies (2 studies). Sources of primary data were healthcare professionals (23 studies), patients (13 studies), and mixed or other sources, including ethnographies (15 studies). The studies are listed in the supplementary appendix.

REMODELLING OF A PRIORI FRAMEWORK

Extracted data were fitted into the starting framework. Following discussion, it was agreed that the data from the sample did not completely map to the *a priori* matrix. Three further categories of stigmatisation were proposed to best fit the findings: ‘rejection’, ‘failure to act’ and an overarching ‘labelling and stereotyping’.

The manifestations of mental health stigma identified in the acute healthcare setting were therefore: devaluation; social control; avoidance; rejection, and failing to act, plus labelling and stereotyping as an overarching concept. These patterns of stigmatisation were identified in the attitudes of health professionals, in their behaviour, and in the structure and organisation of acute care. Positive attitudes and behaviours were also identified that operated as antitheses to these patterns of stigmatisation. The iterated framework is outlined in Table 4.

PATTERNS OF STIGMATISATION

Labelling and stereotyping. Findings suggested that patients with mental health conditions in the acute care system were seen as different. Even when presenting with physical problems, these patients were not always absorbed into the day-to-day work of the emergency department, but were identified as a particular, and often problematic, group.

A significant part of the work of the acute healthcare system lies in the appropriate sorting of patients, and in setting priorities via triage. It is a time-pressured, process-driven system, where categorisations, including medical diagnoses, are necessary for pattern recognition and patient profiling. In the study sample, however, negative associations such as ‘demanding’, ‘challenging’, ‘difficult’ or ‘aggressive’ were frequently attached to those with mental health diagnoses. There were negative stereotypes of subgroups of patients – alcoholics, or the homeless, for example. Simply having any psychiatric diagnosis might be enough to affect care.

‘Once you have been labelled as having a psychiatric illness, it’s very difficult to put that label to one side’. (Doctor, van Nieuwenhuizen et al., 2013).

Negative labels were written into the patient’s record, and lists kept in the emergency department of ‘disruptive’ or ‘drug-seeking’ patients. Labels could remain with that patient and be presented as shorthand information while handing over patients: for example, ‘abusive’, or ‘difficult historian’.

‘If the pigeon-holing of the patient into ‘drug-seeking’ happens at triage, then I think it’s difficult to get that patient out of that niche.’ (Doctor, Henderson et al., 2008).

Devaluing. Social judgement and attitudes. In the literature sample, there were occasional examples of explicit denigration of patients with mental health conditions. In one older study, frequent users of the emergency department – a vulnerable population with a high population of patients with mental illness, drug and alcohol dependence – were described as ‘*animals*’ or ‘*subhuman*’ by nurses (Malone, 1996). In more recent studies, patients with mental health conditions were described as weak, with lack of self-direction, expectation or ability to cope. They were perceived as a drain on resources - material resources, staff, and space - and as a burden on the Emergency Department. Staff felt their time could be better spent on other patients:

‘...they are taking you away from being with someone who is in crisis and really needs you.’ (Nurse, Paterson et al., 2013).

Professional behaviour. In the emergency department, although there were protocols for mental health conditions, the triage system was felt to work better for those with straightforward physical problems. Patients with complex needs or communication difficulties were compromised by the brevity of triage, with nurses struggling to carry out the type of assessment they felt was necessary.

‘With mental health, there is a time factor. I know that out in triage that I don’t have the time.’ (Nurse, Marynowski-Traczyk and Broadbent, 2011).

Once admitted to the department, clinical assessment was also often unsatisfactory. Targets to rapidly dispatch patients deterred clinicians from detailed history-taking, from seeking the views of carers, or from doing full investigations – particularly problematic for patients with complex presentations.

Organisational behaviour. The environment of the Emergency Department was noisy, overcrowded and distracting, and lacked privacy. Often designed purely for physical injury and illness, it was seen as a ‘poor fit’ for those with mental disorders (Marynowski-Traczyk and Broadbent, 2011). This, coupled with long waits, predisposed some with mental health conditions to leave before being seen, or against medical advice.

‘You’d be waiting... sitting there all night and then by the morning I suppose...it’s more important like to get some drink into you than the {chest} pains that you had the night before.’ (Patient, O’Carroll, 2015).

Staff training priorities were reported to de-emphasise mental health conditions and associated problems like homelessness. Furthermore, personnel that might aid healthcare for this patient group, such as a liaison psychiatry service, drug and alcohol advisers, patient advocates and social workers, were frequently either unavailable during off-peak hours - often a peak time for mental health admissions - or not available at all.

‘So the time when we need [the crisis team] is usually at three in the morning on Sunday or Saturday night, and they don’t come to work until Monday’. (Healthcare Professional, Jackson et al., 2014).

Social Control. Social judgement and attitudes. One proposed function of stigma is to maintain social norms (Phelan et al., 2008; Link and Phelan, 2014). There were many examples in which

patients with mental health conditions were perceived as behaving outside the norm. Behaviours poorly tolerated by emergency department staff included patients being verbally or physically demonstrative, swearing, smoking inappropriately or endangering their own healthcare by not complying with medical advice.

Anticipation of disruptive behaviour might arise from previous experience of a patient, particularly in the case of frequent attenders, but could also follow from group stereotyping:

'My past experiences or when I hear about other staff's past stories... negative stories about IV drug users, I always suspect the worst.' (Healthcare Professional, Giandinoto and Edward, 2015).

Escalation of danger to healthcare staff, the public, or the patient was also anticipated.

'High medication schizophrenics disorders - they look at you like they are just about to stab you and it's scary.' (Nurse, Brunero et al., 2017).

Potential disruption by patients added a weight of responsibility and an extra burden of duty as the health professional tried to maintain social boundaries and avoid exacerbating undesired behaviour. Clinicians that allowed patients to behave outside the accepted norm were seen as complicit.

'We condone bad behaviour by giving (pain) meds to verbally and physically abusive people.' (Healthcare professional, Renker et al., 2013).

Professional and organisational behaviour. Healthcare professionals used a number of strategies to achieve social conformity. These included bargaining with patients, trying to 'outwit' them, being firm or shaming them. There was often an element of coercion:

'You have to stay in bed, and you will have to behave or else we will put this back on.' (Healthcare Professional, MacNeela et al., 2012).

Anticipated disruptive behaviour was deterred or circumvented by making patients wait longer before being seen, by physical segregation or by instigating surveillance. Patients were searched, or continuously watched by staff or by security. Disruptive behaviours were often managed by the use of physical or chemical restraints, or by legal structures.

Avoiding. *Social judgement and attitudes.* In a few studies, staff conveyed disgust or discomfort towards those with mental health conditions. This was sometimes on behalf of other patients.

‘Just a bloke sitting there muttering to himself in an incoherent fashion wouldn’t worry me but if you’re sitting (in the waiting room) six foot from him for an hour and half it’s fairly uncomfortable...to have to sit there and tolerate it...it isn’t very nice for them.’ (Healthcare Professional, Knowles et al., 2012).

Professional behaviour. Discomfort around those with mental health conditions could tend to manifest in avoidance of their psychological needs. Staff feared getting ‘too involved’, overwhelmed by emotional outpourings, or having their own sanity challenged. Asking questions about patients’ past lives was avoided because staff found some morally uncomfortable.

‘{He} told me that he had molested a child and I said, ‘Oh god, I don’t think I can take care of this man anymore’’. (Nurse, Crowe, 2012).

Patients might also be avoided physically due to fear of violence.

‘I won’t go back near the patient...you don’t want the patient kicking off and getting angry’ (Nurse, van Nieuwenhuizen et al., 2013).

Professionals would sometimes avoid undressing patients for assessments, or might make fewer clinical observations, or interact for shorter periods with the patient. Communication between staff and patients would be limited to what was considered essential, deliberately maintaining emotional distance.

'By having a set protocol, you're removing any thoughts about the patient yourself.' (Doctor, Hadfield et al., 2009).

Conversation about the patient's mental state was thus evaded, particularly if there was a coexisting physical problem.

'I haven't really got training to sit and talk to them about, you know, their problems and counsel them, so I tend to leave them alone after they have been medically treated.' (Nurse, Hopkins, 2002).

Organisational behaviour. At the organisational level, avoidance was often achieved through transfer of care to the mental health service. Although one of the functions of the Emergency Department is to divert patients toward specialty assessments, studies suggested that, for mental health referral, transfer of responsibility was more abrupt and more absolute.

'Once you are in psychiatry you don't go back to medical.' (Patient, Liggins and Hatcher, 2005)

This created friction between professional teams. Both would try to avoid full responsibility, the mental health service requesting that patients were first 'medically cleared', and the emergency service creating a sense that the patient did not belong to them and was in the wrong place. Passing patients around from service to service, with decisions made serially, prolonged assessment and delayed intervention.

'This chap had taken quite a large overdose. {The emergency doctor's} attitude was... 'I'm not getting involved. Psych need to come and deal with him.' And psychiatry were like, 'Well he's not been medically cleared. We can't get involved....' Unfortunately, the guy died on our clinical decisions unit.' (Healthcare Professional, Shefer et al., 2014).

Rejecting. *Social judgement and attitudes.* Rejection was a new category in the expanded framework. It was associated with a judgement of non-legitimacy, in which a patient was deemed not to be a valid patient, deserving of healthcare.

The idea of non-legitimacy could be expressed in various ways. There was a common perception among healthcare professionals that mental disorders themselves were not 'real'. Clinicians distinguished 'genuine' physical problems from psychosocial problems, and patients were presumed not to have a real problem, even when they had physical symptoms.

'I wasn't taken seriously...there was nothing wrong with you, it's all in your head.' (Patient, Liggins and Hatcher, 2005).

This phenomenon, referred to as diagnostic overshadowing, could result in clinical deterioration and sometimes death, and there were many examples of such scenarios where physical diagnoses were initially missed.

A problem could also be ruled as inappropriate if it was interpreted as 'not an emergency'. Those attending with needs related to long term health conditions, or with vague and ambiguous symptoms, were particularly perceived as inappropriate users of the emergency department. This was even more the case for frequent attenders who could, over time, lose their claim to legitimacy.

Some patients were seen as 'scamming' - presenting a proxy complaint for secondary gains which were not themselves regarded as legitimate. These might be basic needs, such as shelter, food, clothing, showers, pain control, or social contact.

'And they just come here – change of scenery, ride across town, maybe some food... Medicine for aches and pains is, like, secondary.' (Nurse, Malone, 1998).

Scammers could also, according to acute care staff, be misusing medication. Behaviour such as 'clock watching', requesting analgesia at the shortest prescribed interval, or asking for medication by name,

could suggest that the patient was a 'drug seeker'. Others, once labelled with a mental health condition, were interpreted as faking physical symptoms or exaggerating pain. Self-harmers were accused of lacking serious intent.

'If they have taken a small amount of a drug that is harmless, I see it as attention-seeking and such behaviour should not be rewarded by giving more attention.' (Healthcare Professional, Chapman et al., 2014).

Lastly, certain behaviours of those with mental health conditions were regarded as morally 'bad', and thus non-legitimate, if patients were seen to have caused or contributed to the presenting problem. Clinicians would resent the care that was given to these 'undeserving' patients. This was particularly the case for those who had self-harmed, and those with substance and alcohol use disorders.

Professional and organisational behaviour. Non-legitimate patients could be rejected by confrontation and reprimand:

'This is the fourth time in two weeks you've been here. What's wrong with you?' (Junior doctor, Malone, 1996).

Care could be deliberately cursory. Requests, for example for painkillers, might also be rejected.

'If I asked for pain relief [I] was treated like a junkie, they wouldn't up the dose'. (Patient, Blay et al., 2012).

'Non-legitimate' claims to Emergency Department resources by those with mental health conditions resulted in patients being made to wait longer, being excluded from the Emergency Department, or being prevented from admission to hospital.

'They told me in the A&E that they couldn't take me in because I was a drug addict and I made my own choices.' (Patient, O'Carroll, 2015).

Failing to act. *Social judgement and attitudes.* The Emergency Department is regarded as a place of critical care where patients come to be rescued, and, if possible, ‘fixed’. Those with mental health conditions were seen as a threat to this perspective. There was an apparent intractability of the problems for this group that resulted in frustration and threat of professional failure. Patients were seen as not looking after, or investing in their own health, as exhibiting self-destructive behaviour and in not heeding previously given advice. They left the Emergency Department prematurely or with unmet needs, and staff felt their own skillset was inadequate, that they had not done their job properly, or that their interventions were futile.

I’ve actually almost reached the point where I’ve given up a little. (Doctor, Doran et al., 2014).

Frequent attenders could also bring healthcare professionals to a sense of hopelessness and helplessness, as strategies they had tried previously seemed to have failed.

‘You feel like you’re spinning your wheels and you’re like... I don’t feel I’m making a difference in your life.’ (Healthcare Professional, Doran et al., 2014).

Professional and organisational behaviour. The behaviour, in this form of stigmatisation, was ‘giving up’. Ongoing attempts at addressing patient’s needs were, for example, curtailed:

‘At some point I just try less hard...I just think they’re not going to do it.’ (Doctor, Henderson et al., 2008).

A special case of ‘failure to act’ occurred when patients declined medical intervention. Tests of capacity were not necessarily employed or interpreted correctly, and failure to assess the decision-making capacity of patients who refused to engage with professionals resulted in delayed or abandoned care. Use of a legal framework to act in the patient’s best interests was an option either not considered, or, seemingly, not properly understood.

POSITIVE ATTITUDES AND BEHAVIOUR

Positive attitudes and behaviours were fitted into framework categories that were antithetical to the five types of stigmatisation.

Valuing. In contrast to devaluing those with mental health conditions, some staff made an effort to treat all patients equitably as part of their wider duty of care.

‘I come here to work and this is not about me, it’s about caring for this person.’ (Nurse, Liggins and Hatcher, 2005).

In a few examples, patients with mental health conditions were prioritised above others, and staff observed that when they devoted extra time to those with complex mental and physical health needs, they uncovered underlying conditions that had previously been overlooked. Doctors sometimes gave priority admission to those with chaotic lives, to ensure treatment was successful.

Staff would work hard to convince patients to stay for treatment, recognising a duty to keep the patient safe. Professionals also welcomed opportunities to include mental health conditions in their training and professional development.

Adjustment. Instead of judging lifestyle and behaviour as deviant, some staff tried to understand the reasons for a behaviour, putting themselves ‘in the patient’s shoes’, considering their social background, and reframing aggressive behaviour as rooted in anxiety. Healthcare staff might also break the rules themselves, providing unauthorised care, or slipping a patient a cigarette, or a sandwich, or giving away their own lunch.

‘I would rather do something to help somebody and lose my nursing license than to sit back and say ‘Well it’s not within my scope.’ (Nurse, Morgan 2014).

Responding. Similarly, rather than avoiding conversations about mental health and social needs, some staff saw themselves as ‘counsellors’, ‘social workers’ and mediators of behavioural change. Some expressed warmth towards those with mental health conditions, and found them interesting. Relationships between staff and patients became meaningful.

‘For some reason, I’m attached to them like they’re my family or something.’ (Nurse, Malone, 1996).

Professionals ‘cut them some slack’ (Malone, 1996). Staff acquired intimate knowledge of patients’ lives and felt that they were able to make a difference. They were personally affected by the death of a patient with whom a caregiver relationship had been formed.

There were many examples where staff did not feel the need to ‘fix’ patients but saw their duties of care as simply to listen, to understand, to comfort, to calm, and to ensure that patients left happy. Professionals were concerned not to judge or treat people differently because of their personal histories.

My job is not to investigate their life and find out whether they’re innocent or guilty...It changes your opinion and you don’t need to do that. (Nurse, Crowe, 2012).

Care might be interpreted as no more than providing a bed, or a sandwich, and so such patients could be ‘easy’. Healthcare professionals felt useful and rewarded, while patients appreciated staff ‘being nice’ and begun to reveal needs that they hadn’t previously admitted. Instead of transferring responsibility to the mental health services, some general clinicians tried to meet all their needs, physical, mental and social. Staff appreciated the learning experience that these patients provided.

Legitimising. Some health professionals took care not to miss physical diagnoses that might otherwise be overlooked, or misinterpreted as ‘not-physical’. They also recognised that what may be perceived as non-urgent or ‘social’ problems might be matters of significance to the patients, who had come to the emergency department because they had nowhere else to turn. Staff saw a role for

the emergency department as a primary healthcare service; a pathway to recovery; a safe haven; a sobering centre; a temporary shelter; a rehousing centre, a short-term provider of food, warmth and washing facilities, and as having a function in reducing social isolation. ‘Scamming’ was understood as a necessary means to subvert the system to get authentic needs met.

‘It’s kind of sad that you actually have to scam, you know.’ (Nurse, Malone, 1998)

Substance users’ requests for painkillers were believed as genuine, and nurses advocated on their behalf to doctors. Those who self-harmed were perceived as in genuine need of care.

Positive action. Lastly, rather than submitting to ‘futility’, healthcare professionals could take action. This involved believing that recovery and change were not only possible, but could be partially achieved in the emergency department.

‘If I don’t make them feel that, (a) what they have done is important, and (b) something can be done about it and that there are other forms of help that they can get to avoid this happening again, then this {episode of self-harm} is blatantly not going to be an isolated incident.’ (Doctor) (Hadfield et al., 2009).

Thus, patients were referred to ‘quit smoking’ classes, social services and in-house support teams. Healthcare professionals persuaded patients to undergo tests that they were otherwise refusing and, when this approach failed, there were examples where staff utilised mental health and capacity legislation to secure treatment in patients’ best interests.

SECONDARY SAMPLE

Following framework development, data extracted from the secondary sample was ‘fitted’ to the iterated matrix (see Table 4). This confirmed that the five patterns of stigmatisation could be identified in studies outside the main sample. It also demonstrated that all relevant data could be fitted to the iterated framework without requiring further categories. <Insert Table 4 >

HETEROGENEITY

Almost all the papers in this study contained examples of both stigmatising and non-stigmatising attitudes and/or behaviours. There was no obvious relationship with professional role or length of professional experience. Particular mental health conditions did not appear to be specific targets of stigmatisation: all five patterns of stigma together with examples of positive treatment, could be identified across patient subgroups. However, as described above (under Rejection), those who had self-harmed and those with substance and alcohol use disorders may have been more likely to be regarded as morally undeserving of healthcare.

Likewise, stigmatisation was not confined to healthcare organisations or geographical areas, although there was a suggestion that individual attitudes could influence those of the entire setting, particularly from a leadership position. The public safety-net departments in the US also seemed to have a particularly inclusive ethos.

DISCUSSION

SUMMARY OF FINDINGS

This study puts forward a framework for describing stigmatisation towards those with mental health conditions in an acute healthcare setting (see Table 4). It offers a tool for critical analysis of attitudes, individual behaviours and structural discrimination in this, and potentially wider, settings.

Five patterns of stigmatisation were characterised: devaluation; social control; avoidance; rejection, and failure to act. Those with mental health conditions may be devalued in terms of access, assessment and care – and in terms of service design, environmental structure and professional knowledge. They may be subject to social control measures based on anticipated behaviour. Some make staff feel uncomfortable; many are transferred into the care of mental health teams early, with physical conditions being overlooked. They may be seen as undeserving of care, with problems that are ‘not real’, faked, inappropriate, presented too often, or self-imposed. Clinicians grow frustrated; there is a perceived futility around the treatment of this patient group, and staff may abandon their input.

The framework (Table 4) is also potentially transformative, as it identifies the type of care that might be expected if stigmatisation did not exist. In this scenario, patients with mental health conditions are treated respectfully. The system is equitable, and adjustments are made for their difficulties. The environment is adapted to their needs, staff are tolerant, and distress is met with respect and understanding. Patients are recognised as deserving of healthcare, and where they are themselves ambivalent, time is taken to understand their perspective, and act according to their wishes or in their best interests. The sampled literature demonstrates that this type of care is possible, and likely to be everyday behaviour for many health professionals within the acute care system.

Indeed, stigmatising attitudes, differential behaviour and structural discrimination appear to be interwoven with positive treatment of those with mental health conditions in the acute care setting. The framework derived in this study (Table 4) offers a means of disentangling this complex juxtaposition.

RELEVANCE TO EXISTING LITERATURE

Methodologically, this qualitative synthesis aligns with the process of critical realist synthesis outlined by Brannan et al. (2017) who advocate for this approach to meta-analysis.

The finding of stigmatisation in acute general healthcare was unsurprising. Studies have previously implicated healthcare professionals in stigmatisation of those with mental ill health (Thornicroft et al., 2007a; Henderson et al., 2014) while quantitative studies have suggested disparities of acute healthcare toward this group (Mitchell, 2009). Furthermore, a body of sociological literature has revealed the acute healthcare setting as somewhere where stigmatisation might occur. Ethnographic studies describe categorisation by clinicians of patients in the emergency department into ‘good’ and ‘rubbish’ (Jeffery, 1979). Microrationing around low status patients has been observed (Vassey, 2001) and levels of social control in the emergency department were found to be maintained by gatekeeping, redirection and deprioritisation (Hillman, 2014).

The finding that stigmatisation can take many forms was also anticipated. Concepts around stigma were used in constructing the *a priori* matrix - and findings were, of course, partly constrained by this matrix. Nevertheless, it was felt that the identified forms of stigmatisation in this study did usefully distil into the attitudinal, behavioural and structural categories, defined *a priori* from the work of Thornicroft et al. (2007), Corrigan et al. (2004) and others.

The *a priori* matrix included subdivisions that aligned with the ‘down’, ‘in’ and ‘away’ typology characterised by Phelan et al. (2008). The iterated matrix added two further processes, ‘rejection’

(perhaps an ‘out’ process), and ‘failure to act’ (a ‘null’ process). Devaluation, social control, avoidance, rejection and failure to act might thus be abbreviated, respectively, to ‘down’, ‘in’, ‘away’, ‘out’ and ‘null’. The overarching concepts of labelling and stereotyping were not included *a priori*, but were also key parts of Link and Phelan’s conceptualisation of stigma and serve as preconditions for stigmatising processes (2001).

There are also interesting parallels between the five patterns of stigmatisation and Young’s Five Faces of Oppression (2005) which, in a critical realist sense, may suggest ways in which stigma may ‘emerge’ at macro-levels of society, or ways in which cultural oppression of a group can emerge at organisational and individual levels (see Table 5). <Insert Table 5>

Lastly, by identifying positive care as well as negative, the current study highlights the struggle between stigmatisation and benevolence in the acute healthcare setting. Ballatt and Campling (2011) introduced the term ‘intelligent kindness’ for what might be termed counterstigmatising behaviour. According to them, intelligent kindness, or professional compassion, is lacking in the modern, over-industrialised, healthcare system. Particularly at risk are those stigmatised groups ‘on the edges of kinship’ such as those with mental health conditions. Ballatt and Campling (2011) discuss how opposing pressures on healthcare professionals might both elicit, and discourage, intelligent kindness toward such groups. A recent extended case study of a homeless, alcohol-dependent frequent user of the Emergency Department illustrates the precarity of such a dichotomy, and the profound impact of the positive and negative attitudes and behaviours on individual lives (Salhi, 2020). The findings from the current study provide a framework for further analysing these antagonistic processes from a sociological perspective.

LIMITATIONS

Although critical realist synthesis has been advocated by Brannan et al. (2017), there are disadvantages of using a qualitative literature sample to spot the ‘partial regularities’ that might

provide an insight into ontological reality. Each study will lack some contextual information, and extraction of data from even that limited information removes further context.

Methodological limitations included the fact that study selection and data extraction was largely performed by one reviewer (AP), overseen by the other two authors. Associated problems of reliability and bias were mitigated to some extent by monthly in-depth group discussion and the use of techniques (after Lincoln and Guba, 1985) including referential adequacy and review of deviant cases.

The assignation of data to categories of stigmatisation sometimes demanded a judgement about the meaning behind an attitude or behaviour – a meaning that may have been lost in the interpretation of primary data away from context. There is also a risk of shoehorning data into categories, mitigated again by discussion between authors, and by the iterative development of the framework.

A related risk is that the framework (Table 4) sets up a view of polarised attitudes and behaviour as either stigmatising or benevolent, losing understanding of the complex and nuanced attitudes and behaviours that are possibly more representational of the healthcare setting. Our argument would be that the framework aids understanding of these complexities, providing that such rigid polarised attributions are resisted in its application.

Where possible, we distinguished stigmatisation from medically warranted treatment, and professional frustrations (which may not in themselves be stigmatising) from the organisational bases for these frustrations (which sometimes are). Sometimes it was not clear that attitudes and judgements were in response to knowledge that a patient did have a mental health condition – for example, there may be an immediate emotional response on being confronted with a disturbed patient. In the context of the Emergency Department, it is likely that a degree of pre-judgement and

stereotyping takes place even without a diagnostic label, but in the sample this was not always explicit.

The screened literature was heavily slanted toward studies from higher income countries, and the sample pool reflected this. Stigmatisation might be expressed differently in lower income countries, where the structure of the healthcare system and local culture would impact on the findings. Additionally, of the papers included in the study, 80% were based on interviews, focus groups, and other reports of attitudes/behaviour, rather than naturalistic observation. The question thus arises whether behaviours and, to a lesser degree, organisational structures, would have been enacted if observations had been done naturalistically. This opens an avenue for future research.

Lastly, the qualitative synthesis was constrained to a particular setting. We would tentatively propose, however, that the framework may have applicability beyond acute general healthcare to other aspects of healthcare and, indeed, more generalised settings.

UTILITY OF THE FRAMEWORK

Within the area of focus for this study - those with mental health conditions in the acute hospital setting - there is potential for immediate translation to practice. Stigmatisation might be targeted both at the level of individual attitudes and behaviours, and at a structural level (see Table 6). The framework (Table 4) might be used as a quality of care tool, with interventions targeted at outcomes across the quality of care dimensions: safety, effectiveness, patient centredness, timeliness, efficiency, and equitable care. <Insert Table 6>

At professional level, this might be around staff training, which could be both knowledge-based or values-based, or by having staff working alongside experts by experience, or by promoting exposure to patient self-advocacy groups. It might include focus on reflective practice, and quality of care measures, including monitoring of patient feedback, audits of care, and reviews of significant incidents and serious cases. At organisational level, the framework (Table 4) supports attention to

policy, training curricula, the environment, human resources and care pathways. Finally, the framework (and the underpinning critical realist paradigm) illustrates how stigma might ‘emerge’ at different levels. Thus, improving organisational structures might reduce professional frustration; a policy of tolerance and reasonable adjustments might improve individual attitudes, and allowing staff the freedom to speak out about inequities might improve the quality of care in the organisation.

Evidently, stigmatisation of vulnerable groups in the acute healthcare setting is not confined to those with mental health problems but is described towards the poor (Allen et al., 2014); the elderly (Deasey et al., 2014); patients with certain conditions such as sickle cell disease (Jenerette et al., 2010) and dementia (Houghton et al., 2016); patients with intellectual disabilities (Ali et al., 2013); people who are transgender (Chisholm-Straker et al., 2017, Willging et al, 2019), and so on. Using the framework to examine attitudes, behaviours and organisational response could be useful in mapping stigma against these other vulnerable groups in the acute healthcare system.

Finally, although this qualitative synthesis was undertaken as a mapping exercise, rather than an explanatory one, the framework (Table 4) hopefully offers a contribution to stigma theory. The patterns of stigmatisation may generalise to many other settings which Goffman (1963) termed ‘mixed contacts’ – where stigmatisers and stigmatised must interact.

CONCLUSION

In this study, we have used a theory-driven framework synthesis to expand on existing social theory. The sampled literature demonstrates that those with mental health conditions who access the acute general healthcare system may be stigmatised at both professional and structural levels. Given that their presentations are predominantly for physical health problems, this is a matter for concern. The framework developed in this study (see Table 4) explores and describes such inequitable care – patients may be devalued, controlled, avoided, rejected and failed by professionals and the system. Conversely, the framework also describes counter-stigmatising healthcare, where patients are valued, adjusted to, responded to, legitimised and deemed to merit positive action.

A common goal of all general healthcare systems should be to tackle stigma, and we propose that the stigmatisation framework (Table 4) may help in developing a path to this goal.

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INTRODUCTION

People with long-term mental health conditions are frequent users of the acute general healthcare system (Dorning et al., 2015). Many individuals with psychotic disorders, personality disorders, mood and anxiety disorders, and drug and alcohol use disorders have poor general health, with increased risk of developing long-term physical conditions (Hert et al., 2011; Thornicroft, 2011; BMA 2014; Woodhead et al., 2014). Their overall life expectancy is considerably reduced; by one to two decades in higher income countries such as the UK, Scandinavia and Australia, and three decades in, for example, rural Ethiopia (Chang et al., 2011; Hayes et al., 2011; Wahlbeck et al., 2011; Fok et al., 2012; Lawrence et al., 2013; Nordentoft et al., 2013; Fekadu et al., 2015; Olfson et al., 2015). Patients with such mental health conditions are more likely to attend the emergency department, and to be subsequently admitted, than those without (Keene et al., 2007; Dorning et al., 2015). In a 2015 report, 81% of such admissions in English NHS hospitals were for physical problems, and not for problems directly related to their mental health condition (Dorning et al., 2015).

It is therefore concerning that patients with mental disorders report negative attitudes and discrimination in the acute healthcare setting (Clarke et al., 2007). Studies have shown stigmatizing attitudes towards this group among acute care staff (Clarke et al., 2014, Henderson et al., 2014), while interview- and survey-based studies of health professionals indicate that stigma may affect decision-making (Hert et al., 2011; McCormack et al., 2013; Clarke et al., 2014). Furthermore, quantitative disparities in acute clinical care for patients with mental health conditions have been widely described (Mitchell et al., 2009).

Does stigmatization therefore lead to lower quality of care, and worse outcomes, for those with mental health conditions in the acute healthcare setting? The situation is not straightforward, due to the complexities of presentation and high social needs of such patients, who healthcare professionals often view as challenging (Happell et al., 2012; Shefer et al., 2014). Stigmatizing

practices might also be mitigated by professional ethos, perceived duties of care, and compassion (McCormack et al., 2013). Disentangling these factors is key to ensuring that this patient group receive high quality of care that is safe, effective, patient-centred, timely, efficient, and equitable (Knaak et al., 2015). This study was undertaken to synthesise the qualitative literature, to better understand how patients with mental health conditions are stigmatized, or otherwise, in the acute healthcare system.

STIGMATIZATION

Stigma, a 'spoiled identity', was originally described by Goffman from an interactionist perspective (Goffman, 1963) and early stigma theory emphasized the effects of stigma on the individual. While this enabled a sophisticated understanding of the effects of stigma, it hindered recognition of stigmatization as an action 'done' to an individual, and the differential treatment of vulnerable groups may have passed unchallenged. More recently there has been a shift toward approaching stigma from a critical viewpoint, focusing on the individual or structure 'doing' the stigmatizing. From this perspective, stigmatization has been aligned with concepts of prejudice, discrimination, and oppression (Phelan et al., 2008; Scambler, 2009; Holley, 2012). Defining stigma as co-occurrence of its components, of labelling, stereotyping, separation, status loss, and discrimination, Link and Phelan (2001) assert that for stigmatization to occur, power must be exercised. This 'stigma power' (Link and Phelan, 2014) is seen as a form of 'symbolic power', a concept introduced by Bourdieu (1989). Proposed functions of stigma power are to keep out-groups 'down', or dominated/exploited; to keep them 'in', in order to maintain social norms; and to keep them 'away', a process characterised by patterns of avoidance (Phelan et al., 2008; Link and Phelan, 2014).

In the current study we wished to maintain this critical viewpoint and apply it to a group of people identified by a mental health condition. The Weiss (2006) formulation provides a working definition of health-related stigma which aligns with a critical perspective:

Stigma is typically a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted.

The latter part of this definition, ‘medically unwarranted’, is pertinent to the acute healthcare setting, and helps distinguish the social process of stigmatisation from ‘ordinary’ categorization, clinical decision-making, everyday frustrations, and pragmatics of acute patient care.

The current study also differentiates stigmatizing attitudes from stigmatizing behaviours, as proposed by Thornicroft et al. (2007). Within ‘stigmatizing attitudes’ we include emotional responses, which Link et al. (2004), added to their earlier stigma conceptualization.

CRITICAL REALISM

This study was designed within a critical realist paradigm (Bhaskar, 2013) which has been proposed as a useful metatheoretical approach to qualitative synthesis (Brannan et al., 2017). The components of critical realism are ontological realism, epistemic relativism, judgmental rationality, and a cautious ethical naturalism (Archer et al., 2016). Critical realism regards constructs such as stigmatization as reflecting an underlying social reality (‘ontological realism’), although, epistemologically we cannot ‘know’ this reality. We need to be aware of this limitation (‘epistemic relativism’), and social processes like stigmatization need to be interpreted contextually and relatively. We can, however, identify partial regularities that help to understand ways in which stigmatisation operates.

Another useful theme of critical realism is ‘emergence’, in which social entities can be regarded as stratified. Patterns of stigmatization might ‘emerge’ at intrapersonal, interpersonal, and

structural levels. This concept aligns with the individual and structural forms of stigmatization, as described by Corrigan (2000).

The critical realist perspective thus allows mapping of partial regularities across qualitative sources of different designs, and from different settings, at different sociological levels. This practice is carried out in the current study by systematic synthesis, using 'judgemental rationality'. Through a critical realist lens, there is also an acknowledgement that concepts such as stigmatization are value-laden, and that investigation of stigmatization has something to say about values ('ethical naturalism'). There is a dialectical aspect to social ills such as stigma, and identifying instances where such ills are overcome is a key step in moving toward transformation (Bhaskar, 2008). To fully understand stigmatization, it must therefore be necessary to identify positive attitudes and behaviors as well as stigmatization, while being mindful of setting up a falsely dichotomous view of 'good' and 'bad' care. This awareness of positive attitudes as well as stigmatization might then help in understanding complexities of care, and how alternatives to stigma may translate to everyday practice, and thus aid in design of a transformative approach via staff- and organizational-level interventions.

METHOD

AIM AND SCOPE

The aim of this study was to identify patterns of stigmatization in qualitative studies that focus on the care of those with mental health conditions in the acute healthcare setting.

The synthesis involved qualitative studies. It excluded a body of quantitative literature addressing inequalities of acute healthcare for those with mental disorders (Mitchell et al., 2009) because many such studies are from the US, where intricacies of the health system complicate analysis and interpretation. Furthermore, these studies generally do not illuminate the processes that

lead to inequalities: there is rarely any distinction made, for example, between patients who were not offered a procedure, and those who declined a procedure, nor whether informed choices were made, and appropriate adjustments considered. Qualitative studies permit deeper exploration of issues, and were deemed more useful in developing a theory-based model.

STUDY DESIGN

Methodologies for qualitative synthesis are diverse. Most are based, like the primary literature they aim to synthesise, on inductive techniques. Since we wished to use existing stigma theories to drive the synthesis, we chose a deductive ‘best fit’ framework approach to synthesis that utilizes and expands on an *a priori* conceptual model (Carroll et al., 2011). As a variation of this approach, stigma theory was used to define the preliminary framework.

Existing theoretical models of stigma were used to construct an *a priori* framework (Table 1). This framework incorporated the ‘down’, ‘in’, and ‘away’ stigma functions described by Phelan et al. (2008). The framework also distinguished stigmatizing attitudes from stigmatizing behaviours (Thornicroft et al., 2007), and individual and structural forms of stigmatization (Corrigan 2000). Also incorporated were ‘contra-stigmatizing’ attitudes and behaviours.

<Insert Table 1>

SEARCH STRATEGY

The search strategy was designed to keep the total yield manageable (see Table 2). Only English language studies from 1996-2019 were included. Criteria were grouped in columns and search words in each column searched simultaneously (eg Mental OR Schizophren* OR Bipolar OR...). Initially, the group combinations shown in the table were searched for in Titles only. Study design was then added as a further constraint, focus terms searched within Titles, and remaining terms searched within Titles and Abstract.

<Insert Table 2>

{FOCUS AND (Setting OR Comorbidity) AND (Perspective OR Differential OR Decisions)} [Titles]

OR

FOCUS [Titles] AND {(Setting OR Comorbidity)[Titles/Abstract] AND (Perspective OR Differential OR Decisions) [Titles / Abstract] AND (Study design) [Titles / Abstract]}

The searches were initially undertaken in 2016 for years 1996-2016, and repeated in August 2019 for years 2016-19 only. The following databases were searched: Medline / Pubmed / Google Scholar / Embase / PsychArticles / PsycINFO / HMIC / Social Policy and Practice / Global Health / Web of Science / Social Science (Proquest) / British Nursing / Applied Social Sciences Index & Abstracts / Cumulative Index to Nursing and Allied Health Literature / King's College London Library / Cochrane / Public Health / King's Fund / Picker Institute / Healthwatch / National Institute for Health and Care Excellence (NICE)/ Social Policy Research Unit. An example search is illustrated in the Appendix.

SAMPLING STRATEGY

Due to the theory-driven aims of the study and the divergent subject matter, a closed 'set' of studies for inclusion in the review was not sought. Like previous authors of syntheses (Dixon-Woods et al., 2005), we used sampling techniques derived from primary qualitative research, including purposive sampling, maximum variation, and snowballing to identify the literature sample. In our approach, we generated a large sampling frame from an initial broad search, using varied search terms and large number of databases. Inclusion and exclusion criteria were used to narrow the sample (see Table 3). In complex studies that met both inclusion and exclusion criteria, studies were retained for further appraisal.

<Insert Table 3>

Snowballing was used to expand the sample by backwards and forwards chaining. Backwards chaining was achieved by appraising studies drawn from the references within the literature sample. Forwards chaining was undertaken by identifying papers that had cited those in the sample, in order to identify more recently published papers of significance. Abstracts and full texts were screened by the primary reviewer (AP) according to the screening sheet (see Figure S1 in the online supplement).

STUDY SELECTION

After appraisal of the full text by the primary reviewer (AP), studies were selected on the basis of two further criteria: if they were relevant to the aim of the current study, and if they had internal validity. Perceived quality of a study was not used as a criterion as we believed that studies of relatively low quality might still contain useful findings. Care was also taken to ensure the widest possible variation of features including study type, subgroup of patients studied, geographical setting, and type of participant.

Study relevance was regarded as any of the following: direct exploration of stigma; examination of professionals' attitudes; reports or investigation of differential care; and naturalistic studies of the acute healthcare of those with mental health conditions. Where these elements are a clear central features of the study, this study was deemed to have strong relevance to the synthesis.

Internal validity was judged using criteria of consistency and logic: that is, the aims and objectives; the methods of data collection and the analyses and presentation of findings were derivable from the methodology. For narrative pieces such as case reports, there needed to be a sequential account of events, rather than simply description and opinion. Logical consistency was judged by the primary reviewer (AP) and papers of uncertain internal validity were discussed within the group monthly alongside those of debatable relevance.

After discussion, the studies were divided into two groups: the primary sample for analysis and a secondary sample. The secondary sample consisted of studies that fulfilled inclusion criteria only to a limited extent (for example, where much of the study was quantitative in design), were only tangentially relevant, or were from 'grey' (unpublished) sources such as doctoral theses. Reviewers considered the possibility that these studies might contain patterns of stigmatization that would be overlooked in the framework. These studies were therefore maintained to ensure completeness and check validity of the framework after it was developed (see below).

DATA EXTRACTION

Data extracted from studies were any that were considered as stigmatisation after appraisal, followed if necessary by group discussion. This categorization might include a professional's attitude - either cognitive or emotional -, professional behaviour, or organizational structure. The Weiss (2006) definition of stigma above was considered in identifying relevant data. Specifically, stigmatization was identified if attitudes, behaviours, or structures appeared to arise from an adverse social judgment based on the presence of a mental health condition, and if that judgment was medically unwarranted. In some instances, where the text did not make some of these aspects clear, discussion among reviewers was used to decide whether a particular instance should be considered stigmatisation. Data were extracted from the results sections of individual papers and included descriptions of primary data, and examples of primary data (usually quotations).

FRAMEWORK DEVELOPMENT

Data were fitted, where possible, into the *a priori* framework by the primary reviewer (AP). Primary data and descriptions of findings that did not appear to belong in the matrix were recorded separately. At monthly meetings, the emerging matrix was reviewed, and the fitting of data within categories was critiqued, with reference to original papers to provide context where necessary.

Decisions to leave data out of the *a priori* matrix were critically challenged, and this data was set aside.

Non-fitting data were discussed as 'deviant cases' and commonalities were sought. New categories were proposed to the group, with reattempts to fit the data into these categories. This process continued until the expanded framework was considered to encompass all identified patterns of stigmatization of those with mental health conditions in the sample pool, as well as contrasting examples of positive treatment.

The final framework was applied to the secondary sample to ensure saturation of concepts and validity of the framework. This technique corresponds to that described by Lincoln and Guba (1985) as 'referential adequacy'. It also served to overcome any issues of reliability, where individual appraisers might differ as to the relevance of the study, as less relevant studies were maintained in the second sample. An updated search sample for the years 2016-2019 was also checked against the final framework, to ensure that further patterns of stigmatization had not become identifiable since the original search. A flowchart for this study (Figure 1) conveys an idea of the iterative processes involved.

<Insert Figure 1>

RESULTS

LITERATURE SAMPLE

The initial search yielded 2345 papers, with the updated (2016-2019) search adding a further 889 papers and 153 abstracts that met inclusion criteria were screened. The full texts of these papers were analysed for exclusion criteria and 89 papers that met criteria were selected for a snowballing approach using backwards and forwards chaining. Backwards chaining was achieved by selecting relevant studies from the references within the paper, and forwards chaining using the 'cited by'

function of Google Scholar. A pool of 199 papers were then appraised in full, and 51 papers were subdivided into a main sample ($k=26$) and a secondary sample ($k=25$). The main sample consisted of 26 papers of relevance published between 1996 and 2016, which contributed the data for the framework development. The secondary sample consisted of unpublished works (four studies); published works of lower relevance ($k=10$); and papers from an updated search, from 2016-19 ($k=11$).

The full sample comprised interview and focus group studies ($k=28$), ethnographies ($k=8$), case reports ($k=4$), and 11 mixed or other studies. The studies addressed: acute physical presentations to hospital in those with mental disorders (three studies); acute general healthcare of those with mental disorders ($k=16$); tangential socially-defined groups in the acute hospital setting (the homeless; frequent attenders; violent patients) where those with mental disorders featured significantly ($k=11$); those with substance or alcohol use disorder and physical health needs in the acute hospital setting ($k=10$); those with an acute presentation related to self-harm ($k=5$); those with a physical presentation and co-existing mental disorder who declined intervention ($k=4$); and uncategorized relevant studies ($k=2$). Sources of primary data were healthcare professionals ($k=23$), patients ($k=13$), and mixed or other sources, including ethnographies ($k=15$). The studies are listed in the supplementary appendix.

REMODELLING OF A *PRIORI* FRAMEWORK

Extracted data were fitted into the starting framework. Following discussion, it was agreed that the data from the sample did not completely map to the *a priori* matrix. Three further categories of stigmatisation were proposed to best fit the findings: 'rejection', 'failure to act', and an overarching 'labelling and stereotyping'.

The manifestations of mental health stigma identified in the acute healthcare setting were therefore: devaluation, social control, avoidance, rejection, and failing to act, plus labelling and stereotyping as an overarching concept. These patterns of stigmatisation were identified in the

attitudes of health professionals, in their behaviour, and in the structure and organisation of acute care. Positive attitudes and behaviours were also identified that operated as antitheses to these patterns of stigmatisation. The iterated framework is outlined in Table 4.

PATTERNS OF STIGMATISATION

Labelling and stereotyping. Findings suggested professionals within the acute care system viewed patients with mental health conditions as different. Even when presenting with physical problems, these patients were not always assimilated into the day-to-day work of the emergency department, but were identified as a particular, and often problematic, group. A significant part of the work of the acute healthcare system lies in the appropriate sorting of patients, and in setting priorities via triage. It is a time-pressured, process-driven system, where categorizations, including medical diagnoses, are necessary for pattern recognition and patient profiling. In the study sample, negative associations such as ‘demanding’, ‘challenging’, ‘difficult’ or ‘aggressive’ were frequently attached to those with mental health diagnoses. There were negative stereotypes of subgroups of patients – alcoholics, or the homeless, for example. Simply having any psychiatric diagnosis might be enough to affect care.

‘Once you have been labelled as having a psychiatric illness, it’s very difficult to put that label to one side’. (Doctor, van Nieuwenhuizen et al., 2013).

Negative labels were written into the patient’s record, and lists kept in the emergency department of ‘disruptive’ or ‘drug-seeking’ patients. Labels could remain with that patient and be presented as shorthand information while handing over patients: for example, ‘abusive’, or ‘difficult historian’:

‘If the pigeon-holing of the patient into ‘drug-seeking’ happens at triage, then I think it’s difficult to get that patient out of that niche.’ (Doctor, Henderson et al., 2008).

Devaluing. Social judgement and attitudes. In the literature sample, there were occasional examples of explicit denigration of patients with mental health conditions. In one older study, frequent users of the emergency department – a vulnerable population with many patients with mental illness and drug and alcohol dependence – were described as ‘*animals*’ or ‘*subhuman*’ by nurses (Malone, 1996). In more recent studies, patients with mental health conditions were described as weak, with lack of self-direction, expectation, or ability to cope. They were perceived as a drain on resources including material resources, staff, and space and as a burden on the Emergency Department. Staff felt their time could be better spent on other patients:

‘...they are taking you away from being with someone who is in crisis and really needs you.’
(Nurse, Paterson et al., 2013).

Professional behaviour. In the emergency department, although there were protocols for mental health conditions, the triage system was felt to work better for those with straightforward physical problems. Patients with complex needs or communication difficulties were compromised by the brevity of triage, with nurses struggling to carry out the type of assessment they felt was necessary.

‘With mental health, there is a time factor. I know that out in triage that I don’t have the time.’ (Nurse, Marynowski-Traczyk and Broadbent, 2011).

Once admitted to the department, clinical assessment was also often unsatisfactory. Targets to rapidly dispatch patients deterred clinicians from detailed history-taking, seeking the views of carers, or doing full investigations – particularly problematic for patients with complex presentations.

Organizational behaviour. The environment of the Emergency Department was noisy, overcrowded, distracting, and lacked privacy. Often designed purely for physical injury and illness, it was seen as a ‘poor fit’ for those with mental disorders (Marynowski-Traczyk and Broadbent, 2011).

These factors, coupled with long waits, predisposed some with mental health conditions to leave before being seen, or against medical advice.

'You'd be waiting... sitting there all night and then by the morning I suppose...it's more important like to get some drink into you than the {chest} pains that you had the night before.'
(Patient, O'Carroll, 2015).

Staff training priorities were reported to de-emphasize mental health conditions and associated problems like homelessness. Furthermore, personnel that might aid healthcare for this patient group, such as a liaison psychiatry service, drug and alcohol advisers, and patient advocates and social workers, were frequently either unavailable during off-peak hours - often a peak time for mental health admissions - or not available at all.

'So the time when we need [the crisis team] is usually at three in the morning on Sunday or Saturday night, and they don't come to work until Monday'. (Healthcare Professional, Jackson et al., 2014).

Social Control. Social judgement and attitudes. One proposed function of stigma is to maintain social norms (Phelan et al., 2008; Link and Phelan, 2014). There were many examples in which emergency department staff perceived patients with mental health conditions as behaving outside the norm. Behaviors poorly tolerated by emergency department staff included patients being verbally or physically demonstrative, swearing, smoking inappropriately, and endangering their own healthcare by not complying with medical advice.

Anticipation of disruptive behaviour might arise from previous experience of a patient, particularly in the case of frequent attenders, but could also result from group stereotyping:

'My past experiences or when I hear about other staff's past stories... negative stories about IV drug users, I always suspect the worst.' (Healthcare Professional, Giandinoto and Edward, 2015).

Escalation of danger to healthcare staff, the public, or the patient was also anticipated.

'High medication schizophrenics disorders - they look at you like they are just about to stab you and it's scary.' (Nurse, Brunero et al., 2017).

Potential disruption by patients added a weight of responsibility and an extra burden of duty as the health professional tried to maintain social boundaries and avoid exacerbating undesired behavior. Clinicians that allowed patients to behave outside the accepted norm were seen as complicit.

'We condone bad behaviour by giving (pain) meds to verbally and physically abusive people.' (Healthcare professional, Renker et al., 2013).

Professional and organisational behaviour. Healthcare professionals used a number of strategies to achieve social conformity. These included bargaining with patients, trying to 'outwit' them, being firm, and shaming them. There was often an element of coercion:

'You have to stay in bed, and you will have to behave or else we will put this back on.' (Healthcare Professional, MacNeela et al., 2012).

Healthcare professionals deterred or circumvented anticipated disruptive behaviour by making patients wait longer before being seen, by physical segregation, and by instigating surveillance. Patients were searched, or continuously watched by staff or by security. Disruptive behaviours were often managed by the use of physical or chemical restraints, or by legal structures.

Avoiding. Social judgement and attitudes. In a few studies, staff conveyed disgust or discomfort towards those with mental health conditions. These reactions were sometimes on behalf of other patients.

'Just a bloke sitting there muttering to himself in an incoherent fashion wouldn't worry me but if you're sitting (in the waiting room) six foot from him for an hour and half it's fairly uncomfortable...to have to sit there and tolerate it...it isn't very nice for them.' (Healthcare Professional, Knowles et al., 2012).

Professional behaviour. Discomfort around those with mental health conditions could potentially manifest in avoidance of their psychological needs. Staff feared getting 'too involved', overwhelmed by emotional outpourings, or having their own sanity challenged. Asking questions about patients' past lives was avoided because staff found some morally uncomfortable.

'{He} told me that he had molested a child and I said, 'Oh god, I don't think I can take care of this man anymore''. (Nurse, Crowe, 2012).

Patients might also be avoided physically due to fear of violence.

'I won't go back near the patient...you don't want the patient kicking off and getting angry' (Nurse, van Nieuwenhuizen et al., 2013).

Professionals would sometimes avoid undressing patients for assessments, or might make fewer clinical observations, or interact for shorter periods with the patient. Communication between staff and patients would be limited to what was considered essential, deliberately maintaining emotional distance.

'By having a set protocol, you're removing any thoughts about the patient yourself.' (Doctor, Hadfield et al., 2009).

Conversation about the patient's mental state was thus evaded, particularly if there was a coexisting physical problem.

'I haven't really got training to sit and talk to them about, you know, their problems and counsel them, so I tend to leave them alone after they have been medically treated.' (Nurse, Hopkins, 2002).

Organizational behaviour. At the organizational level, avoidance was often achieved through transfer of care to the mental health service. Although one of the functions of the Emergency Department is to divert patients toward specialty assessments, studies suggested that, for mental health referral, transfer of responsibility was more abrupt and more absolute.

'Once you are in psychiatry you don't go back to medical.' (Patient, Liggins and Hatcher, 2005)

This transfer of patients and responsibility created friction between professional teams. Both would try to avoid full responsibility, the mental health service requesting that patients were first 'medically cleared', and the emergency service creating a sense that the patient did not belong to them and was in the wrong place. Passing patients around from service to service, with decisions made serially, prolonged assessment and delayed intervention.

'This chap had taken quite a large overdose. {The emergency doctor's} attitude was... 'I'm not getting involved. Psych need to come and deal with him.' And psychiatry were like, 'Well he's not been medically cleared. We can't get involved....' Unfortunately, the guy died on our clinical decisions unit.' (Healthcare Professional, Shefer et al., 2014).

Rejecting social judgement and attitudes. Rejection was a new category in the expanded framework. It was associated with a judgement of non-legitimacy, in which a patient was deemed not to be a valid patient, deserving of healthcare. The idea of non-legitimacy could be expressed in various ways. There was a common perception among healthcare professionals that mental disorders themselves were not 'real'. Clinicians distinguished 'genuine' physical problems from psychosocial

problems, and patients were presumed not to have a real problem, even when they had physical symptoms.

'I wasn't taken seriously...there was nothing wrong with you, it's all in your head.' (Patient, Liggins and Hatcher, 2005).

This phenomenon, referred to as diagnostic overshadowing, could result in clinical deterioration and sometimes death, and there were many examples of such scenarios where physical diagnoses were initially missed.

A problem could also be ruled as inappropriate if it was interpreted as 'not an emergency'. Those attending with needs related to long-term health conditions, or with vague and ambiguous symptoms, were particularly perceived as inappropriate users of the emergency department. This was even more the case for frequent attenders who could, over time, lose their claim to legitimacy. Some patients were seen as 'scamming' - presenting a proxy complaint for secondary gains which were not themselves regarded as legitimate. These might be basic needs, such as shelter, food, clothing, showers, pain control, or social contact.

'And they just come here – change of scenery, ride across town, maybe some food... Medicine for aches and pains is, like, secondary.' (Nurse, Malone, 1998).

Scammers could also, according to acute care staff, be misusing medication. Behaviour such as 'clock watching', requesting analgesia at the shortest prescribed interval, or asking for medication by name, could suggest that the patient was a 'drug seeker'. Others, once labelled with a mental health condition, were interpreted as faking physical symptoms or exaggerating pain. Self-harmers were accused of lacking serious intent.

'If they have taken a small amount of a drug that is harmless, I see it as attention-seeking and such behaviour should not be rewarded by giving more attention.' (Healthcare Professional, Chapman et al., 2014).

Lastly, certain behaviors of those with mental health conditions were regarded as morally 'bad', and thus non-legitimate, if patients were seen to have caused or contributed to the presenting problem. Clinicians would resent the care that was given to these 'undeserving' patients. This scenario was particularly the case for those who had self-harmed, and those with substance and alcohol use disorders.

Professional and organisational behaviour. Non-legitimate patients could be rejected by confrontation and reprimand:

'This is the fourth time in two weeks you've been here. What's wrong with you?' (Junior doctor, Malone, 1996).

Care could be deliberately cursory. Requests, for example for painkillers, might also be rejected.

'If I asked for pain relief [I] was treated like a junkie, they wouldn't up the dose'. (Patient, Blay et al., 2012).

'Non-legitimate' claims to Emergency Department resources by those with mental health conditions resulted in patients being made to wait longer, being excluded from the Emergency Department, or being prevented from admission to hospital.

'They told me in the A&E that they couldn't take me in because I was a drug addict and I made my own choices.' (Patient, O'Carroll, 2015).

Failing to act. Social judgement and attitudes. The Emergency Department is regarded as a place of critical care where patients come to be rescued, and, if possible, 'fixed'. Those with mental health conditions were seen as a threat to this perspective. There was an apparent intractability of the problems for this group that resulted in frustration and threat of professional failure. Patients were seen as not looking after, or investing in their own health, as exhibiting self-destructive

behavior, and in not heeding previously given advice. They left the Emergency Department prematurely or with unmet needs, and staff felt their own skillset was inadequate, that they had not done their job properly, or that their interventions were futile.

I've actually almost reached the point where I've given up a little. (Doctor, Doran et al., 2014).

Frequent attenders could also bring healthcare professionals to a sense of hopelessness and helplessness, as strategies they had tried previously seemed to have failed.

'You feel like you're spinning your wheels and you're like... I don't feel I'm making a difference in your life.' (Healthcare Professional, Doran et al., 2014).

Professional and organisational behavior. The behavior, in this form of stigmatization, was 'giving up'. Ongoing attempts at addressing patient's needs were, for example, curtailed:

'At some point I just try less hard...I just think they're not going to do it.' (Doctor, Henderson et al., 2008).

A special case of 'failure to act' occurred when patients declined medical intervention. Tests of capacity were not necessarily employed or interpreted correctly, and failure to assess the decision-making capacity of patients who refused to engage with professionals resulted in delayed or abandoned care. Use of a legal framework to act in the patient's best interests was an option either not considered, or, seemingly, not properly understood.

POSITIVE ATTITUDES AND BEHAVIOUR

Positive attitudes and behaviours were fitted into framework categories that were antithetical to the five types of stigmatization.

Valuing. In contrast to devaluing those with mental health conditions, some staff made an effort to treat all patients equitably as part of their wider duty of care.

'I come here to work and this is not about me, it's about caring for this person.' (Nurse, Liggins and Hatcher, 2005).

In a few examples, patients with mental health conditions were prioritised above others, and staff observed that when they devoted extra time to those with complex mental and physical health needs, they uncovered underlying conditions that had previously been overlooked. Doctors sometimes gave priority admission to those with chaotic lives, to ensure treatment was successful. Staff would work hard to convince patients to stay for treatment, recognising a duty to keep the patient safe. Professionals also welcomed opportunities to include mental health conditions in their training and professional development.

Adjustment. Instead of judging lifestyle and behavior as deviant, some staff tried to understand the reasons for a behavior, putting themselves 'in the patient's shoes', considering their social background, and reframing aggressive behaviour as rooted in anxiety. Healthcare staff might also break the rules themselves, providing unauthorized care, or slipping a patient a cigarette or a sandwich, or giving away their own lunch.

'I would rather do something to help somebody and lose my nursing license than to sit back and say 'Well it's not within my scope.' (Nurse, Morgan 2014).

Responding. Similarly, rather than avoiding conversations about mental health and social needs, some staff saw themselves as 'counsellors', 'social workers', and mediators of behavioural change. Some expressed warmth towards those with mental health conditions, and found them interesting. Relationships between staff and patients became meaningful.

'For some reason, I'm attached to them like they're my family or something.' (Nurse, Malone, 1996).

Professionals '*cut them some slack*' (Malone, 1996). Staff acquired intimate knowledge of patients' lives and felt that they were able to make a difference. They were personally affected by the death of a patient with whom a caregiver relationship had been formed.

There were many examples where staff did not feel the need to 'fix' patients but saw their duties of care as simply to listen, to understand, to comfort, to calm, and to ensure that patients left happy. Professionals were careful not to judge or treat people differently because of their personal histories.

My job is not to investigate their life and find out whether they're innocent or guilty...It changes your opinion and you don't need to do that. (Nurse, Crowe, 2012).

Care might be interpreted as no more than providing a bed, or a sandwich, and so such patients could be 'easy'. Healthcare professionals felt useful and rewarded, while patients appreciated staff 'being nice' and began to reveal needs that they hadn't previously admitted. Instead of transferring responsibility to the mental health services, some general clinicians tried to meet all their needs, physical, mental, and social. Staff appreciated the learning experience that these patients provided.

Legitimizing. Some health professionals took care not to miss physical diagnoses that might otherwise be overlooked, or misinterpreted as 'not-physical'. They also recognised that what may be perceived as non-urgent or 'social' problems might be matters of significance to the patients, who had come to the emergency department because they had nowhere else to turn. Staff saw a role for the emergency department as a primary healthcare service; a pathway to recovery; a safe haven; a sobering center; a temporary shelter; a rehousing center; a short-term provider of food, warmth and washing facilities; and as having a function in reducing social isolation. 'Scamming' was understood as a necessary means to subvert the system to get authentic needs met.

'It's kind of sad that you actually have to scam, you know.' (Nurse, Malone, 1998)

Substance users' requests for painkillers were believed as genuine, and nurses advocated on their behalf to doctors. Those who self-harmed were perceived as in genuine need of care.

Positive action. Lastly, rather than submitting to 'futility', healthcare professionals could take action. This decision involved believing that recovery and change were not only possible, but could be partially achieved in the emergency department.

'If I don't make them feel that, (a) what they have done is important, and (b) something can be done about it and that there are other forms of help that they can get to avoid this happening again, then this {episode of self-harm} is blatantly not going to be an isolated incident.' (Doctor) (Hadfield et al., 2009).

Thus, patients were referred to 'quit smoking' classes, social services, and in-house support teams. Healthcare professionals persuaded patients to undergo tests that they were otherwise refusing and, when this approach failed, there were examples where staff utilized mental health and capacity legislation to secure treatment in patients' best interests.

SECONDARY SAMPLE

Following framework development, data extracted from the secondary sample was 'fitted' to the iterated matrix (see Table 4). This process confirmed that the five patterns of stigmatization could be identified in studies outside the main sample. It also demonstrated that all relevant data could be fitted to the iterated framework without requiring further categories.

<Insert Table 4 >

HETEROGENEITY

Almost all the papers in this study contained examples of both stigmatizing and non-stigmatizing attitudes and/or behaviours. There was no obvious relationship with professional role or length of professional experience. Particular mental health conditions did not appear to be specific

targets of stigmatization: all five patterns of stigma together with examples of positive treatment could be identified across patient subgroups. As described above (under Rejection), those who had self-harmed and those with substance and alcohol use disorders may have been more likely to be regarded as morally undeserving of healthcare.

Likewise, stigmatization was not confined to healthcare organizations or geographical areas, although there was a suggestion that individual attitudes could influence those of the entire setting, particularly from a leadership position. The public safety-net departments in the US also seemed to have a particularly inclusive ethos.

DISCUSSION

SUMMARY OF FINDINGS

This study puts forward a framework for describing stigmatization towards those with mental health conditions in an acute healthcare setting (see Table 4). It offers a tool for critical analysis of attitudes, individual behaviors, and structural discrimination in this, and potentially wider, settings. Five patterns of stigmatization were characterized: devaluation; social control; avoidance; rejection; and failure to act. Those with mental health conditions may be devalued in terms of access, assessment, and care – and in terms of service design, environmental structure, and professional knowledge. They may be subject to social control measures based on anticipated behavior. Some make staff feel uncomfortable; many are transferred into the care of mental health teams early, with physical conditions being overlooked. They may be seen as undeserving of care, with problems that are ‘not real’, faked, inappropriate, presented too often, or self-imposed. Clinicians grow frustrated; there is a perceived futility around the treatment of this patient group, and staff may abandon their input.

The framework (Table 4) is also potentially transformative, as it identifies the type of care that might be expected if stigmatisation did not exist. In this scenario, patients with mental health

conditions are treated respectfully. The system is equitable, and adjustments are made for their difficulties. The environment is adapted to their needs, staff are tolerant, and distress is met with respect and understanding. Patients are recognised as deserving of healthcare, and when they are themselves ambivalent, time is taken to understand their perspective, and act according to their wishes or in their best interests. The sampled literature demonstrates that this type of care is possible, and likely to be everyday behavior for many health professionals within the acute care system.

Indeed, stigmatizing attitudes, differential behavior, and structural discrimination appear to be interwoven with positive treatment of those with mental health conditions in the acute care setting. The framework derived in this study (Table 4) offers a means of disentangling this complex juxtaposition.

RELEVANCE TO EXISTING LITERATURE

Methodologically, this qualitative synthesis aligns with the process of critical realist synthesis outlined by Brannan et al. (2017) who advocate for this approach to meta-analysis.

The finding of stigmatization in acute general healthcare was unsurprising. Studies have previously implicated healthcare professionals in stigmatization of those with mental ill health (Thornicroft et al., 2007a; Henderson et al., 2014) while quantitative studies have suggested disparities of acute healthcare toward this group (Mitchell, 2009). Furthermore, a body of sociological literature has revealed the acute healthcare setting as somewhere stigmatization might occur. Ethnographic studies describe categorization by clinicians of patients in the emergency department into 'good' and 'rubbish' (Jeffery, 1979). Micro-rationing around low status patients has been observed (Vassey, 2001) and levels of social control in the emergency department were found to be maintained by gatekeeping, redirection, and deprioritization (Hillman, 2014).

The finding that stigmatization can take many forms was also anticipated. Concepts around stigma were used in constructing the *a priori* matrix - and findings were partly constrained by this matrix. Nevertheless, it was felt that the identified forms of stigmatization in this study did usefully distil into the attitudinal, behavioural, and structural categories, defined *a priori* from the work of Thornicroft et al. (2007), Corrigan et al. (2004) and others. The *a priori* matrix included subdivisions that aligned with the 'down', 'in' and 'away' typology characterised by Phelan et al. (2008). The iterated matrix added two further processes, 'rejection' (perhaps an 'out' process), and 'failure to act' (a 'null' process). Devaluation, social control, avoidance, rejection, and failure to act might thus be abbreviated, respectively, to 'down', 'in', 'away', 'out', and 'null'. The overarching concepts of labelling and stereotyping were not included *a priori*, but were also key parts of Link and Phelan's conceptualisation of stigma and serve as preconditions for stigmatising processes (2001). There are also interesting parallels between the five patterns of stigmatization and Young's Five Faces of Oppression (2005) which, in a critical realist sense, may suggest ways in which stigma may 'emerge' at macro-levels of society, or ways in which cultural oppression of a group can emerge at organizational and individual levels (see Table 5). <Insert Table 5>

Lastly, by identifying positive care as well as negative, the current study highlights the struggle between stigmatization and benevolence in the acute healthcare setting. Ballatt and Campling (2011) introduced the term 'intelligent kindness' for what might be termed counter-stigmatizing behavior. According to them, intelligent kindness, or professional compassion, is lacking in the modern, over-industrialized, healthcare system. Particularly at risk are those stigmatized groups 'on the edges of kinship' such as those with mental health conditions. Ballatt and Campling (2011) discuss how opposing pressures on healthcare professionals might both elicit, and discourage, intelligent kindness toward such groups. A recent extended case study of a homeless, alcohol-dependent frequent user of the Emergency Department illustrates the precarity of such a dichotomy, and the profound impact of the positive and negative attitudes and behaviors on individual lives (Salhi, 2020). The findings from

the current study provide a framework for further analysing these antagonistic processes from a sociological perspective.

LIMITATIONS

Although Brannan et al. (2017) have advocated for critical realist synthesis, there are disadvantages of using a qualitative literature sample to spot the ‘partial regularities’ that might provide an insight into ontological reality. Each study will lack some contextual information, and extraction of data from even that limited information removes further context.

Methodological limitations included the fact that study selection and data extraction were largely performed by one reviewer (AP), overseen by the other two authors. Associated problems of reliability and bias were mitigated to some extent by monthly in-depth group discussion and the use of techniques (after Lincoln and Guba, 1985) including referential adequacy and review of deviant cases.

The assignation of data to categories of stigmatization sometimes demanded a judgement about the meaning behind an attitude or behaviour – a meaning that may have been lost in the interpretation of primary data away from context. There is also a risk of shoehorning data into categories, mitigated again by discussion between authors, and by the iterative development of the framework. A related risk is that the framework (Table 4) sets up a view of polarized attitudes and behaviors as either stigmatizing or benevolent, losing understanding of the complex and nuanced attitudes and behaviors that are possibly more representational of the healthcare setting. Our argument would be that the framework aids understanding of these complexities, providing that such rigid polarized attributions are resisted in its application.

Where possible, we distinguished stigmatization from medically warranted treatment, and professional frustrations (which may not in themselves be stigmatising) from the organizational bases for these frustrations (which sometimes are). Sometimes it was not clear that attitudes and

judgements were in response to knowledge that a patient did have a mental health condition – for example, there may be an immediate emotional response on being confronted with a disturbed patient. In the context of the Emergency Department, it is likely that a degree of pre-judgement and stereotyping takes place even without a diagnostic label, but in the sample this was not always explicit.

The screened literature was heavily slanted toward studies from higher income countries, and the sample pool reflected this. Stigmatization might be expressed differently in lower income countries, where the structure of the healthcare system and local culture would impact the findings. Additionally, of the papers included in the study, 80% were based on interviews, focus groups, and other reports of attitudes/behaviour, rather than naturalistic observation. The question thus arises whether behaviors and, to a lesser degree, organizational structures, would have been enacted if observations had been naturalistic. This query opens an avenue for future research.

Lastly, the qualitative synthesis was constrained to a particular setting. Despite this potential limitation, we would tentatively propose that the framework may have applicability beyond acute general healthcare to other aspects of healthcare and, indeed, more generalized settings.

UTILITY OF THE FRAMEWORK

Within the area of focus for this study - those with mental health conditions in the acute hospital setting - there is potential for immediate translation to practice. Stigmatization might be targeted both at the level of individual attitudes and behaviors, and at a structural level (see Table 6). The framework (Table 4) might be used as a quality of care tool, with interventions targeted at outcomes across the quality of care dimensions: safety, effectiveness, patient centredness, timeliness, efficiency, and equitable care. <Insert Table 6>

At the professional level, increased care quality might be implemented through staff training, which could be both knowledge-based or values-based, or by having staff work alongside experts and

gain experience, or by promoting exposure to patient self-advocacy groups. It might include focus on reflective practice, and quality of care measures, including monitoring of patient feedback, audits of care, and reviews of significant incidents and serious cases. At an organizational level, the framework (Table 4) supports attention to policy, training curricula, the environment, human resources, and care pathways. Finally, the framework (and the underpinning critical realist paradigm) illustrates how stigma might ‘emerge’ at different levels. Thus, improving organizational structures might reduce professional frustration; a policy of tolerance and reasonable adjustments might improve individual attitudes; and allowing staff the freedom to speak out about inequities might improve the quality of care in the organization.

Evidently, stigmatization of vulnerable groups in the acute healthcare setting is not confined to those with mental health problems but is described towards the poor (Allen et al., 2014); the elderly (Deasey et al., 2014); patients with certain conditions such as sickle cell disease (Jenerette et al., 2010) and dementia (Houghton et al., 2016); patients with intellectual disabilities (Ali et al., 2013); people who are transgender (Chisholm-Straker et al., 2017, Willging et al, 2019); and so on. Using the framework to examine attitudes, behaviors, and organizational response could be useful in mapping stigma against these other vulnerable groups in the acute healthcare system.

Finally, although this qualitative synthesis was undertaken as a mapping exercise, rather than an explanatory one, the framework (Table 4) hopefully offers a contribution to stigma theory. The patterns of stigmatization may generalize to many other settings which Goffman (1963) termed ‘mixed contacts’ – where those perpetuating stigmatization and those who experience stigmatization must interact.

CONCLUSIONS

In this study, we have used a theory-driven framework synthesis to expand on existing social theory. The sampled literature demonstrates that those with mental health conditions who access the

acute general healthcare system may be stigmatized at both professional and structural levels. Given that their presentations are predominantly for physical health problems, this issue is a matter for concern. The framework developed in this study (see Table 4) explores and describes such inequitable care – patients may be devalued, controlled, avoided, rejected, and failed by professionals and the system. Conversely, the framework also describes counter-stigmatizing healthcare, where patients are valued, adjusted to, responded to, legitimized, and deemed to merit positive action. A common goal of all general healthcare systems should be to tackle stigma, and we propose that the stigmatization framework (Table 4) may help in developing a path to this goal.

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Table 1. *A priori* analytic framework matrix.

STIGMATISATION			CONTRA-STIGMATISATION		
<i>Professional attitudes</i>	<i>Professional behaviour</i>	<i>Structural / organisational behaviour</i>	<i>Professional attitudes</i>	<i>Professional behaviour</i>	<i>Structural / organisational behaviour</i>
	Keeping 'down' / Devaluation Keeping 'in' / Social Control Keeping 'away' / Avoidance			Valuing Tolerating / Making Positive Adjustments Responding	

Table 2. Search strategy in which columns are combined, initially within titles, and then, constraining by study design group, within titles/abstracts.

SETTING	FOCUS	COMORBIDITY	PERSPECTIVE	DIFFERENTIAL	DECISIONS	DESIGN
Acute	Mental	Trauma	Experience	Equity	Decision-making	Qualitative
Emergency	Schizophreni*	Coronary	Satisfaction	Inequity	Rationing	Interview*
Medical	Bipolar	Cardiac	Empower*	Inequality	Priorit*	Focus Group*
Hospital	Personality Disorder	Heart	Perspective	Fairness	Triage	Ethnograph*
	Homeless	Myocardial	View*	Stigma	Resuscitation	Observation*
	Addict*	Respiratory	Perceived	Discrimination	Delay	
	Substance	Chest	Attitude*	Prejudice	Diagnostic overshadowing	
	Depression	Abdominal	Perception	Stereotype		
	Eating Disorders	Musculo-skeletal	Futility	Inclusive		
	Self-harm	Stroke		Disparity		
	Self-poisoning	Neurological		Marginalised		
		Injury				

Table 3. Inclusion and exclusion criteria.

	PARTICIPANTS	SUBJECT FOCUS	SETTING OR SPECIALISM	TYPE OF STUDY
INCLUDED	Health professionals Patients Carers	Severe mental disorder including substance use disorder	Acute healthcare (Emergency Department; Acute wards)	Qualitative Primary studies
EXCLUDED	Students Non-healthcare professionals	Common mental disorders Dementia Intellectual disability	Primary care Outpatient care Elective (non-urgent) care Cancer care Specialist mental health care Off-site focus e.g. interviews with staff in a non-professional context, or patients about their general life experience	Purely quantitative (including psychometric measures) Interventions Evaluations Reviews Syntheses and meta- analyses

Table 4. Iterated framework.

<i>PATTERNS OF STIGMATISATION</i>	STEREOTYPING AND LABELLING (OVERARCHING)				
	DEVALUATION	SOCIAL CONTROL	AVOIDANCE	REJECTION	FAILURE TO ACT
<i>Social judgement about patients with mental health conditions</i>	Lower worth	Deviant	Unwelcome	Not urgent Not 'real' Not deserving	Unable to be helped
<i>Attitudes</i>	Denigration	Disapproval	Discomfort	Blaming Disallowing	Frustration
<i>Professional behaviour</i>	Compromised care	Shaming Bargaining Confronting	Physical avoidance Emotional detachment	Diagnostic overshadowing Requests withheld	Inaction Failure to consider legal options
<i>Organisational behaviour</i>	Lower priority group Insufficient resources for complexity of need Unsuitable environment Low training priority	Segregation Surveillance Restraint Law enforcement	Abdication of responsibility	Exclusion Ejection	Absence of structural mechanisms to assess capacity or risk to self because of mental state
<i>Counter-judgement</i>	Valued, equal	Accepted	Welcomed	Legitimate	Meriting positive action
<i>Positive treatment</i>	Prioritisation Equity of care	Tolerance Adjustments	Responsiveness	Inclusion	Active care Acting in best interests of one who lacks decision-making capacity

Table 5. Five patterns of healthcare stigmatisation compared with Young's (2005) five faces of oppression.

<i>Patterns of healthcare stigmatisation (this study)</i>	DEVALUATION	SOCIAL CONTROL	AVOIDANCE	REJECTION	FAILURE TO ACT
<i>Faces of oppression (Young, 2005)</i>	Exploitation	Cultural Imperialism	Marginalisation	Violence	Powerlessness
<i>Common features</i>	Disfavouring of an 'out' group for the benefit of the 'in' group	Penalisation; perceived deviance from an imposed norm	Confining to the edges of a social system	Blaming, reprimanding, eliminating	Inaction; creating a culture of incapacity

Table 6. Potential ways to reduce structural discrimination towards those with mental health conditions in acute healthcare.

	<i>Ways to reduce stigmatisation at professional level</i>	<i>Ways to reduce stigmatisation at organisational level</i>
STEREOTYPES & LABELS	Discourage inappropriate labelling in staff handovers Counterstereotype interventions (Lai et al, 2014) Anti-stigma training (Henderson et al, 2014)	Avoid group-specific discriminatory policies Avoid lists of problematic patients Avoid 'special codes' on notes
DEVALUATION	Staff training focus on vulnerable patient groups Audits of care to ensure equity Patient feedback and response to this Specific training of triage nurses about needs of those with mental health conditions	Allow longer time to triage patients with complex needs Provide low-stimulus patient waiting areas Provide 24/7 advocates, advisors and specialist teams Introduce mechanisms to advise patients who wish to leave before being seen Focus training curricula on vulnerable patient groups
SOCIAL CONTROL	Exposure to patient self-advocacy groups Simulation training Significant incident reviews	Emphasise mediation and de-escalation techniques Minimise use of surveillance and security personnel Minimise use of chemical, physical and legal restraints
AVOIDANCE	Staff exposure to those with mental health conditions Staff participation in Schwarz Rounds (Lown & Manning, 2010) Encourage reflective practice	Parallel input from physical and mental healthcare teams Employment of experts by experience in the acute care system
REJECTION	Training around awareness of diagnostic overshadowing Increase knowledge about physical health inequalities and complex needs	Open access policy for patients Avoid 'front door' mechanisms to turn patients away
FAILURE TO ACT	Increase knowledge of legal structures eg Mental Capacity Act (UK) Serious case reviews	Improve access pathways to accessory services Assess mental capacity in patients who decline treatment Quality of Care monitoring

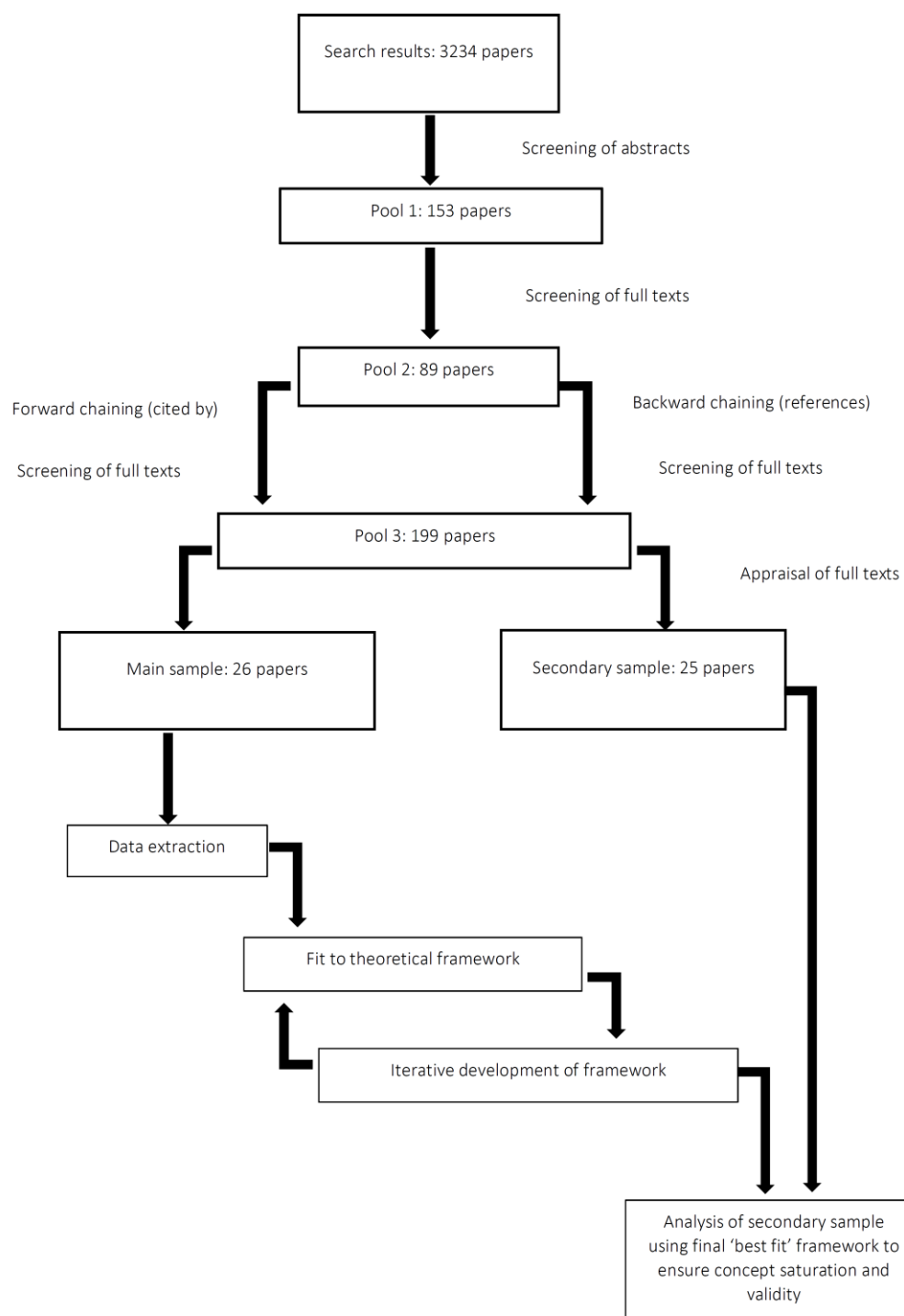


Fig. 1. Sampling strategy and framework development flowchart

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Stigmatisation of those with mental health conditions in the acute general hospital setting. A qualitative framework synthesis

Ethics Statement

This is a review paper and contains no data that has not been published or is outside the public domain.

Secondary data in the paper is subject to ethical approval obtained for the original studies. It links to those studies but does not contain identifiable data.

Ethical approval is not required for this study.

Highlights

- Stigmatisation of those with mental health conditions is found in acute healthcare.
- The study synthesises qualitative literature to understand these processes.
- We identify five key patterns of stigmatisation, at individual and structural levels.
- These are: devaluation, social control, avoidance, rejection and failure to act.
- We highlight how this framework may contribute to improving quality of care.